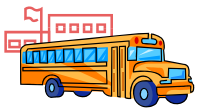

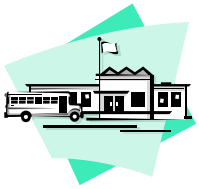

# *School-Based Services*

## *Medicaid and Other Medical Assistance Programs*

MONTANA
Department of Public Health & Human Services

**April 2008**

*This publication supersedes all previous School-Based Services handbooks. Published by the Montana Department of Public Health & Human Services, August 2003.*

*Updated October 2003, December 2003, January 2004, April 2004, August 2004, April 2005, May 2005, August 2005, January 2006, April 2006, February 2007, April 2008.*



**My NPI:**

MONTANA
Department of Public Health & Human Services

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# Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

## Provider Enrollment

For enrollment changes or questions:

**(800) 624-3958** In and out-of-state
**(406) 442-1837** Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

## Provider Relations

For questions about eligibility, PASSPORT, payments, denials, general claims questions, or to request provider manuals or fee schedules:

**(800) 624-3958** In and out-of-state
**(406) 442-1837** Helena
**(406) 442-4402** Fax

Send e-mail inquiries to:
MTPRHelpdesk@ACS-inc.com

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

## Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

**(800) 624-3958** In and out-of-state
**(406) 442-1837** Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

## Claims

Send paper claims and adjustment requests to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

## Restricted Client Authorization

For authorization for emergency services provided for restricted clients, contact the Surveillance/Utilization Review Section:

**(406) 444-4167**

All other services must be authorized by the client's designated provider.

## Client Help Line

Clients who have general Medicaid or PASSPORT questions may call the Client Help Line:

**(800) 362-8312**

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

## EDI Technical Help Desk

For questions regarding electronic claims submission:

**(800) 987-6719**In and out-of-state
**(406) 442-1837**Helena
**(406) 442-4402**Fax

Send e-mail inquiries to:
MTPRHelpdesk@ACS-inc.com

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

## Provider Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the G*eneral Information For Providers* manual.

## Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

## CSCT Program

For more information on the Comprehensive School and Community Treatment (CSCT) program, contact the school-based program specialist.

**(406) 444-4066** Phone
**(406) 444-3846** Fax

Send written inquiries to:

School-Based Program Specialist
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

For inquiries related to licensure/endorsement, contact the Quality Assurance Division, licensing Bureau:

**(406) 444-2676** Phone
**(406) 444-1742** Fax

Send written inquiries to:

Quality Assurance Division
Licensing Bureau
2401 Colonial Drive, Third Floor
Helena, MT 59602-2693

## Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

**(406) 444-5283**

## CHIP Program

**(877) 543-7669** Phone toll-free in and out-of-state
**(406) 444-6971** Phone in Helena
**(406) 444-4533** Fax in Helena
**(877) 418-4533** Fax Toll-free in and out-of-state
**chip@mt.gov** E-mail

CHIP Program Officer
P.O. Box 202951
Helena, MT 59620-2951

## Chemical Dependency Bureau

For coverage information and other details regarding chemical dependency treatment, write or call:

**(406) 444-3964** Phone

Send written inquiries to:

Chemical Dependency Bureau
Addictive and Mental Disorders Division
DPHHS
P.O. Box 202905
Helena, MT 59620-2905

## Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

### *Mountain-Pacific Quality Health Foundation*

For questions regarding prior authorization for school-based private duty nursing services:

**(406) 443-4020 ext. 150** Helena
**(800) 262-1545 ext. 150** Outside Helena:
**(406) 443-4585** Fax

## Prior Authorization (continued)

Send written inquiries to:

Medicaid Utilization Review
Department
Mountain Pacific Quality Health
Foundation
P.O. Box 6488
Helena, MT 59604-6488

For questions regarding prior authorization for medical necessity therapy reviews:

**(406) 457-5887** Local
**(877) 443-4021 X5887** Toll-free
**(877) 443-2580** Fax local and long distance

Send written inquiries to:

Mountain Pacific Quality Health
Foundation
3404 Cooney Drive
Helena, MT 59604

### *First Health*

For questions regarding prior authorization and continued stay review for selected mental health services.

**(800) 770-3084** Phone
**(800) 639-8982** Fax
**(800) 247-3844** Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

## Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

## Team Care Program Officer

For questions regarding the Team Care Program:

**(406) 444-4540** Phone
**(406) 444-1861** Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

## Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

**(406) 444-4540** Phone
**(406) 444-1861** Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

## Key Web Sites

| Web Address | Information Available |
|---|---|
| **Provider Information Website**<br>www.mtmedicaid.org | • Medicaid news<br>• Provider manuals<br>• Notices and manual replacement pages<br>• Fee schedules<br>• Remittance advice notices<br>• Forms<br>• Provider enrollment<br>• Frequently asked questions (FAQs)<br>• Upcoming events<br>• HIPAA Update<br>• Newsletters<br>• Key contacts<br>• Links to other websites and more |
| **CHIP Website**<br>www.chip.mt.gov | • Information on the Children's Health Insurance Plan (CHIP) |
| **ACS EDI Gateway**<br>www.acs-gcro.com/Medicaid_Account/Montana/montana.htm | ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on:<br>• Provider Services<br>• EDI Support<br>• Enrollment<br>• Manuals<br>• Software<br>• Companion Guides |
| **Washington Publishing Company**<br>www.wpc-edi.com | • EDI implementation guides<br>• HIPAA implementation guides and other tools<br>• EDI education |

MONTANA
Department of Public Health & Human Services

# Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

## Manual Organization

This manual provides information specifically for the school-based services program.

Each chapter has a section titled *Other Programs* that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP). Other essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your NPI for quick reference when calling Provider Relations.

## Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy. Notices and replacement pages are available on the Provider Information website (see *Key Contacts*).

Providers are responsible for knowing and following current laws and regulations.

## Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rule references are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office

(see *Key Contacts*). The following rules and regulations are specific to the school based services program. Additional Medicaid rule references are available in the *General Information For Providers manual*.

- Administrative Rules of Montana (ARM)
  - ARM 37.86.2201 EPSDT Purpose, Eligibility and Scope
  - ARM 37.86.2206 - 2207 EPSDT Medical and Other Services; Reimbursement
  - ARM 37.86.2217 EPSDT Private Duty Nursing
  - ARM 37.86.2224-2233 EPSDT, CSCT and Health Related Services

## Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Contacts*).

## Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid provider's claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

## Program Overview

Title XIX of the Social Security Act provides for a program of medical assistance to certain individuals and families with low income. This program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the federal and state governments. Federal oversight for the Medicaid program lies with the Centers for Medicare and Medicaid Services (CMS) in the Department of Public Health and Human Services (DPHHS).

# Covered Services

## General Coverage Principles

Medicaid covers health-related services provided to children in a school setting when all of the following are met:

- The child qualifies for Individuals with Disabilities Education Act (IDEA)
- The services are written into an Individual Education Plan (IEP)
- The services are not free. Providers may not bill Medicaid for any services that are generally offered to all clients without charge
- For CSCT services, children must have a serious emotional disturbance (SED) diagnosis as specified under ARM 37.86.3702(2).

Refer to the IEP requirements in this chapter and the Coordination of Benefits chapter regarding billing services included/not included in a child's IEP.

This chapter provides covered services information that applies specifically to school-based services. School-based services providers must meet the Medicaid provider qualifications established by the state and have a provider agreement with the state. These providers must also meet the requirements specified in the *School-Based Services* manual and the *General Information For Providers* manual. School-based services provided to Medicaid clients include the following:

- Therapy services (physical therapy, occupational therapy, speech language pathology)
- Audiology
- Private duty nursing
- School psychology and mental health services (including clinical social work and clinical professional counseling)
- Comprehensive School and Community Treatment (CSCT)
- Personal care (provided by paraprofessionals)
- Other diagnostic, preventative and rehabilitative services
- Specialized transportation

### *Services for children (ARM 37.86.2201 – 2221)*

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all school-based services described in this manual. All applicable prior authorization requirements apply (see the *Prior Authorization* chapter in this manual).

### *Services within scope of practice (ARM 37.85.401)*

Services provided under the school-based services program are covered only when they are within the scope of the provider's license.

### *Provider requirements*

Most school-based services must be provided by licensed health care providers. The exception is that activities of daily living services may be provided by personal care paraprofessionals. Medicaid does not cover services provided by a teacher or teacher's aide; however, teachers or teacher aides may be used to assist in the development of child care planning. School-based services must be provided by only those providers listed in the table below.

| Provider Type | Provider Requirements |
|---|---|
| Private duty nursing services provided by:<br>• Licensed registered nurse<br>• Licensed practical nurse | Nurses must have a valid certificate of registration issued by the Board of Nurse Examiners of the State of Montana or the Montana Board of Nursing Education and Nurse Registration. |
| Mental health services provided by:<br>• Credentialed school psychologist<br>• Licensed psychologist<br>• Licensed clinical professional counselor<br>• Licensed clinical social worker | Mental health providers must be licensed according to Montana's state requirements. School psychologist services are provided by a professional with a Class 6 specialist license with a school psychologist endorsement. |
| Therapy services provided by:<br>• Licensed occupational therapist<br>• Licensed physical therapist<br>• Licensed speech language pathologists | These therapists are required to meet appropriate credentialing requirements as defined by the Montana Licensing Board. |
| Audiology | Must meet credentialing requirements as defined by the Montana Licensing Board |
| Personal care paraprofessional | No licensing requirements |
| Comprehensive School & Community Treatment (CSCT) | Must be provided by a licensed mental health center with a CSCT endorsement |

It is the responsibility of the school district to assure appropriately licensed providers perform all Medicaid covered services. Each school district must maintain documentation of each rendering practitioner's license, certification, registration or credential to practice in Montana. Medicaid providers who have had their license suspended by a state or federal government entity may not provide school-based services.

Services provided to Medicaid clients must be documented in the client's IEP.

### *IEP requirements*

Services provided to Medicaid clients must be covered by Medicaid and documented in the client's Individualized Education Plan (IEP), unless otherwise specified. School-based providers may bill Medicaid for Medicaid-covered health-related services provided to children with those services written into the

IEP, even though the services may be provided to non-Medicaid children for free. However, if a child is covered by both Medicaid and private insurance, the private insurance must be billed prior to Medicaid. Exception to billing other insurance: BC/BS of Montana and CHIP.

Medicaid does not cover health-related services that are not included in an IEP unless all of the following requirements are met:

- Youth is enrolled in Medicaid
- Services are medically necessary
- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

### *Client qualifications*

To qualify for Medicaid school-based services, the client must be a Medicaid client and meet all the following criteria:

- Be Medicaid eligible on the date of service
- Be between the ages 3 and 20
- Be entitled to school district services under the Individuals with Disabilities Education Act (IDEA)
- Have Medicaid reimbursable services referenced in his or her Individual Educational Plan (IEP). This shows that Medicaid covered services are recommended by the school district.
- In the case of CSCT services, the client must have an SED diagnosis and services may or may not be included in the client's IEP.

### *School qualifications*

Only public school districts, full-service education cooperatives and joint boards of trustees may enroll in the Montana Medicaid school-based services program. To qualify, the district, cooperative or joint board must receive special education funding from the state's Office of Public Instruction general fund for public education. School districts include elementary, high school and K-12 districts that provide public educational services. Full-service education cooperatives and joint boards include those cooperatives eligible to receive direct state aid payments from the Superintendent of Public Instruction for special education services.

Cooperatives, joint boards, and non-public schools that do not receive state general funds for special education can not participate in the Medicaid program as a school-based provider.

#### Schools that employ medical service providers

- Schools who employ all or most of their medical service providers for whom the school submits bills can be enrolled with a single NPI for all services.

- Schools may use this single NPI to bill for any Medicaid covered service provided by a licensed provider.
- Schools that wish to have separate NPIs for each provider type (e.g., speech therapists, occupational therapists, and physical therapists) can request separate NPIs from the National Plan and Provider Enumeration System (NPPES).

**Schools that contract with external medical service providers**

- Schools that contract with all or most of their providers must have the provider of service bill for each service they provide with their own individual NPI.
- Providers and schools can arrange with the Department for payments to be made to the school. If payments are assigned to the school, the school will also have the responsibility to collect third party liability payments on behalf of the service providers.

For more information on enrollment, visit the Provider Information website or contact Provider Enrollment (see *Key Contacts*).

### *Physician order/referral*

Medicaid does not require physician orders or referrals for health-related services that are documented in the client's IEP. The exception is private duty nursing services and personal care assistant services, which require a written order for private-duty nursing or physician signature for personal care assistance services. Other health-related services can be authorized by a licensed school practitioner meeting the State of Montana provider requirements to secure health-related services under an IEP.

### *Documentation requirements*

School-based services providers must maintain appropriate records. All case records must be current and available upon request. Records can be stored in any readily accessible format and location, and must be kept for six years and three months from the date of service. For more information on record keeping requirements, see the *Surveillance/Utilization Review* chapter in the *General Information For Providers* manual. Medical documentation must include the following:

- Keep legible records!
- Date of service and the child's name
- The service(s) provided during the course of each treatment and how the child responded.
- Except for CSCT, the services for which the school is billing Medicaid must be written into the child's IEP.

### CSCT requirements

A licensed mental health center must have a CSCT endorsement issued by the Quality Assurance Division, Licensing Bureau. For more information on how to apply for program endorsement, contact the Montana Department of Public Health and Human Services (see *CSCT Program* in *Key Contacts*). For information on CSCT Program requirements, see *Appendix C: CSCT Program*.

- ***Services provided by a Mental Health Center.*** Services under the CSCT program must be provided by a school that is a licensed mental health center or a licensed mental health center that has contracted with the schools. Schools are required to lead the program management and are specifically required to meet all of the requirements described in this chapter.
- ***Program endorsed before providing services.*** Program endorsement must be obtained by the licensed mental health center prior to the service implementation in order for school districts or cooperatives to implement CSCT programs.
- ***Program staff requirements.*** Program staff must include at least two mental health workers and one of the two mental health workers must be a licensed psychologist, licensed clinical social worker, licensed professional counselor or in-training mental health professional (ARM 37.88.901). The Department of Public Health and Human Services Licensing Bureau will review an in-training mental health professional but approval is not required for licensed providers.
- ***Children must have serious emotional disturbances*** (ARM 37.86.3702(2))***.*** The CSCT program is intended specifically for children who have serious emotional disturbances, regardless of whether the child is eligible for special education services. This program is not intended for children with functional limitations who require support for activities of daily living (ADL). Children that require ADL support are covered by other Medicaid services like personal care paraprofessionals.
- ***Services must be medically necessary (ARM 37.82.102 and 37.85.410).*** CSCT services must be medically necessary. See *medically necessary* in the *Definitions* section of this manual. Medicaid considers experimental services or services which are generally regarded by the medical profession as unacceptable treatment not medically necessary.
- ***Services must be available to all qualifying children.*** CSCT services must be made available to all children that meet criteria for those services, not just because the child has Medicaid benefits. In the case of school-based programs that provide services to children

that do not have IEPs, Medicaid will pay for covered services if the following are in place:

- A fee schedule is established (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

The exception to this policy is the services that are provided to Medicaid eligible children and the services are written into the children's IEPs (see *IEP Requirements* in this chapter).

- ***Program must follow free care rule.*** Everyone who receives CSCT services must be billed for the services. If a service is free for non-Medicaid clients, then it is free for all children. Medicaid billable services provided under an IEP are not subject to the *free care rule* (see *IEP Requirements* in this chapter).

### Service requirements

The CSCT program must be provided through a program of services staffed by at least two mental health workers who work exclusively in the school. At least one of the two mental health workers must be a licensed psychologist, licensed clinical social worker, licensed professional counselor, or a DPHHS approved in-training mental health professional. The minimum staffing requirement for a program is one team with the capacity to provide up to 720 units per calendar month to children with SED. Part-time staff may be utilized but the billing units must be reduced proportionately.

- *Caseload* refers to the total number of units the CSCT program team may provide in a calendar month. Ideally the staff and CSCT clients should be all contained in one school. It is acceptable, however, for a CSCT program team to provide up to 720 units to be spread across no more than two schools located in close proximity of one another. Coverage by a CSCT team of more than two school campuses is not acceptable.
- The expectation is that the full-time CSCT staff will be available throughout each day to meet the needs of the CSCT clients.
- The use of an "in-training mental health professional" in a CSCT program is allowed on an infrequent and exceptional basis. It is recognized that recruitment of licensed professionals may be difficult in some parts of the state.

  - The in-training mental health professional has completed all academic work required for the license and has begun the post-degree supervised experience required for licensure.
  - A licensed professional has entered into a written agreement to provide supervision of the post degree experience required for licensure.
  - A licensure examination date (or at least an approximate date) has been selected.
  - The in-training mental health professional may serve in lieu of a licensed CSCT staff for no more than 2 years.
  - The in-training mental health professional has had relevant prior experience serving SED children.
- CSCT services must also be available for non-Medicaid clients who meet the CSCT program requirements. In addition to providing these services, districts/cooperatives must also request payment for these services. Services may be billed based on a sliding fee schedule to non-Medicaid children. Schools may contract with their CSCT provider to bill Medicaid, private-pay patients and insurance carriers.
- CSCT services not specified in the IEP must be made available and billed to **all** children who receive services.
- Providers may not bill Medicaid for any CSCT services that are generally offered to all clients without charge.
- CSCT services do not require PASSPORT approval or inclusion in the child's IEP.
- CSCT services must be provided according to an individualized treatment plan. The treatment plan must be reviewed and approved by a licensed professional who is a CSCT staff member.

**Services include**

Strategies, coordination and quality improvement activities related to the individual child's treatment plans are included in the CSCT program.

- Individual, family and group therapy
- Behavior intervention
- Crisis intervention services
- Coordination with other addictive and mental health treatment services the child receives outside the CSCT program
- Access to emergency services
- Continued treatment that includes services during non-school days integrated in a manner consistent with the child or adolescent's treatment plan, and in coordination with the school's administration per the contract.

**Billable Services**

- Face to face service (H0036, 15-minute increment)
    - Individual therapy
    - Family therapy (with child)
    - Group therapy
    - Behavioral interventions
    - Place of service is 03 (schools) or 12 (client's home)

**Services restricted**

Medicaid does not cover the following services under the CSCT program (this list is not all-inclusive):

- Observation and monitoring/supervision
- Non-face to face service
- Watching movies
- Field trips
- Time in meetings
- More than 720 units of service per CSCT team per calendar month
- Prior authorization is required for outpatient therapy services provided concurrently or outside the CSCT program.
- Educational assistance or assisting with homework/tutoring

### *Therapy services*

Therapy includes speech, occupational and physical therapy services. Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the school's supervising licensed therapist's NPI (see the *Billing Procedures* chapter in this manual).

The levels of supervision are as follows:

- General: Procedure is furnished under the licensed provider's direction and control, but the licensed provider's presence is not required during the performance of the procedure.
- Direct: The licensed provider must be present in the office and immediately available to furnish assistance and direction throughout the performance of the procedure. The licensed provider must be in the direct treatment area of the client-related procedure being performed.
- Routine: The licensed provider must provide direct contact at least daily at the site of work, within interim supervision occurring by other methods, such as telephonic, electronic or written communication.
- Temporary Practice Permit holders (new grads from occupational therapy school who are waiting for their national exam results) MUST work under ROUTINE supervision of the licensed therapist. If the exam is failed the Temporary Practice Permit IMMEDIATELY

becomes VOID. Routine supervision requires direct contact at least daily at the site of work.

- Occupational and Speech Therapy Aides require personal, direct supervision by the licensed provider. This means the licensed provider must be face to face with the aide in the same room when procedures are being provided.
- Speech Therapy Aides:
    - Aide 1 = supervised a minimum of 30% while performing diagnostic and interpretive functions in the first year of non-allowable activities. The supervision requirement will be 5% of client contact time, of which 2% shall be direct contact after the first year, at the discretion of the supervising speech-language pathologist
    - Aide 2 = shall be supervised 10% of client contact time, of which 5% shall be direct contact
    - Aide 3 = shall be supervised 20% of client contact time, of which 5% shall be direct contact. Refer to ARM 24.222.702
- Occupational Therapy Assistants require general supervision, meaning the licensed provider does not have to be physically on the premises at the time of the service. However, the licensed therapist must provide face to face supervision at least monthly.
- Physical Therapy Aides/Assistants require general supervision, meaning that the licensed provider must be on the premises.
- Temporarily licensed therapists can never supervise anyone.

### Services included

Covered therapy services include the following:

- Restorative therapy services when the particular services are reasonable and necessary to the treatment of the client's condition and subsequent improvement of function. The amount and frequency of services provided must be indicated on the client's IEP.
- Assessment services to determine client medical needs and/or to establish an IEP, as long as the assessment results in health-related services documented in the IEP.

### Service requirements

For all therapies being billed, they must be included in the student's IEP.

### Services restricted

- Montana Medicaid does not cover therapy services that are intended to maintain a client's current condition but only covers services to improve client functions.

- Therapy services are limited to 40 hours per state fiscal year (July 1 - June 30) for each type of therapy. Note: Early Periodic Screening and Diagnostic Treatment (EPSDT) rules make this limit an exception to the 40 hours.

### *Private duty nursing services*

Private duty nursing services are skilled nursing services provided by a registered or licensed practical nurse.

#### Service requirements

Medicaid covers private duty nursing services when all of the following requirements are met:

- When the client's attending physician or mid-level practitioner orders these services in writing
- When prior authorization (PA) is obtained (see the *PASSPORT and Prior Authorization* chapter in this manual for PA requirements)

### *School psychologists and mental health services*

Psychological services in schools are based on determining eligibility for inclusion in special education programming and not necessarily to determine a medical diagnosis outside of the guidelines of the Individuals with Disabilities Education Act.

#### Services included

Psychological and mental health services include the following:

- Individual psychological therapy
- Psychological tests and other assessment procedures when the assessment results in health-related services being written into the IEP
- Interpreting assessment results
- Obtaining, integrating and interpreting information about child behavior and conditions as it affects learning, if it results in an IEP. This only includes direct face-to-face service.
- Mental health and counseling services that are documented on the client's IEP
- Consultation with the child's parent as part of the child's treatment

#### Service requirements

Medicaid covers psychological counseling services when the following two criteria are met:

- The client's IEP includes a behavior management plan that documents the need for the services

- Service is not provided concurrently with CSCT services (unless prior authorization has been obtained).

#### Services restricted

Montana Medicaid does not cover the following psychological services:

- Testing for educational purposes
- Psychological evaluation, if provided to a child when an IEP is not subsequently established
- Review of educational records
- Classroom observation
- Scoring tests

### *Personal care paraprofessional services*

Personal care paraprofessional services are medically necessary in-school services provided to clients whose health conditions cause them to be limited in performing activities of daily living. That is, these services are provided for clients with functional limitations.

#### Services included

These activities of daily living services include:

- Dressing
- Eating
- Escorting on bus
- Exercising (ROM)
- Grooming
- Toileting
- Transferring
- Walking

#### Service requirements

- These services must be listed on the client's IEP.
- Approval must be given by the client's primary care provider prior to billing for Medicaid covered services. This is done by the use of the Child Profile Form located in Appendix B.

Personal care services are not covered when provided by an immediate family member.

#### Services restricted

Medicaid does not cover the following services provided by a personal care paraprofessional:

- Skilled care services that require professional medical personnel
- Instruction, tutoring or guidance in academics
- Behavioral management

Please see *Appendix B: Personal Care Paraprofessional Services Documentation,* which includes the child profile and service delivery record. The child profile provides detailed examples of activities of daily living.

### *Special needs transportation*

Special needs transportation includes transportation services for clients with special needs that are outside of traditional transportation services provided for clients without disabilities.

#### Services include

Special needs transportation services are covered when all of the following criteria are met:

- Transportation is provided to and/or from a Medicaid-covered service on the day the service was provided
- The Medicaid-covered service is included in the client's IEP
- The client's IEP includes specialized transportation service as a medical need.

Specialized transportation services are covered if one of the following conditions exists:

- A client requires transportation in a vehicle adapted to service the needs of students with disabilities, including a specially adapted school bus
- A client resides in an area that does not have school bus transportation (such as those in close proximity to a school).
- The school incurs the expense of the service regardless of the type of transportation rendered

#### Services included

Special needs transportation includes the following:

- Transportation from the client's place of residence to school (where the client receives health-related services covered by the Montana School-based Services program, provided by school), and/or return to the residence.
- Transportation from the school to a medical provider's office who has a contract with the school to provide health-related services covered by the Montana School-based Services program, and return to school.

The school district must maintain documentation of each service provided, which may take the form of a trip log.

#### Services restricted

Clients with special education needs who ride the regular school bus to school with other non-disabled children in most cases will not have a medical need for transportation services and will not have transportation listed in their IEP. In this case, the bus ride should not be billed to the Montana

School-based Services program. The fact that clients may receive a medical service on a given day does not necessarily mean that special transportation also would be reimbursed for that day.

### *Audiology*

Audiology assessments are performed by individuals possessing the state of Montana credentials for performing audiology services.

#### Services included

Covered audiology services include the following:

- Assessment to determine client's medical needs and/or to establish an IEP, as long as the assessment results in health-related services documented in the IEP.
- Services provided must be documented in the client's IEP.

#### Service requirements

Medicaid covers audiology services when the services to be provided during a school year are written into the child's IEP.

#### Services restricted

Medicaid does not cover the following audiology services:

- Testing for educational purposes
- Services provided during Child Find assessments

Medicaid does not cover special transportation services on a day that the client does not receive a Medicaid-covered service that is written into the IEP.

### *Authorization requirements summary*

The following table is a summary of authorization requirements for school-based services that were described in each section above. For more information on how to obtain prior authorization and PASSPORT provider approval, see the *PASSPORT and Prior Authorization* chapter in this manual.

**Authorization Requirements**

| Service | Prior Authorization | PASSPORT Provider Approval | Written Physician Order/Referral |
|---|---|---|---|
| **CSCT services*** | **No** | **No** | **No** |
| **Therapy services** | **No** | **No** | **No** |
| **Private duty nursing services** | **Yes** | **No** | **Yes** |
| **School psychologist and mental health services** | **No** | **No** | **No** |

## Authorization Requirements (continued)

| Service | Prior Authorization | PASSPORT Provider Approval | Written Physician Order / Referral |
|---|---|---|---|
| **Personal care paraprofessional services** | **No** | **No** | **Yes** (Child Profile Form is signed by child's physician) |
| **Specialized transportation services** | **No** | **No** | **No** |
| **Audiology** | **No** | **No** | **No** |

* Outpatient mental health services provided by a private therapist or mental health professional must have prior approval when providing services concurrently with CSCT (concurrently means services provided during the same time or in combination to a youth that is receiving CSCT services).

## Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

### *Children's Mental Health Services Plan (CMHSP)*

The school-based services in this manual are not covered benefits of the Children's Mental Health Services Plan (CMHSP) administered by the Children's Mental Health Bureau. However, the mental health services in this chapter are covered benefits for Medicaid clients. For more information on the CMHSP program, see the *Mental Health* manual available on the Provider Information website (see *Key Contacts*).

### *Children's Health Insurance Plan (CHIP)*

The school-based services in this manual are not covered benefits of the Children's Health Insurance Plan (CHIP). Additional information regarding CHIP benefits is available by contacting BlueCross BlueShield at 1-800-447-7828 ext. 8647.

## PASSPORT and Indian Health Services

Clients who are eligible for both Indian Health Services (IHS) and Medicaid may choose IHS or another provider as their PASSPORT provider. Clients who are eligible for IHS do not need a referral from their PASSPORT provider to obtain services from IHS. However, if IHS refers the client to a non-IHS provider, the PASSPORT provider must approve the referral.

## Getting questions answered

The *Key Contacts* list (at the front of this manual) provides important phone numbers and addresses. Provider and Client Help Lines are available to answer almost any general Medicaid question.

## Prior Authorization

Some services require prior authorization (PA) before they are provided, such as private duty nursing services. When seeking PA, keep in mind the following:

- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements.
- Have all required documentation included in the packet before submitting a request for PA (see the following *PA Criteria for Specific Services* table for documentation requirements).
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included on the claim.

## PA Criteria for Specific Services

| Service | PA Contact | Requirements |
|---|---|---|
| • **Private Duty Nursing Services** | Medicaid Utilization Review Department<br>Mountain Pacific Quality Health Foundation<br>P.O. Box 6488<br>Helena, MT 59604-6488<br><br>Questions regarding this process can be answered by calling:<br><br>**Helena:**<br>(406) 443-4020 ext. 150<br><br>**Outside Helena:**<br>(800) 262-1545 ext. 150<br><br>**Fax:**<br>(406) 443-4585 | The number of units approved for private duty nursing services is based on the time required to perform a skilled nursing task.<br>• A prior authorization request must be sent to the Medicaid Utilization Review Department's peer review organization accompanied by a physician or mid-level practitioner order/referral for private duty nursing.<br>• Prior authorization must be requested at the time of initial submission of the nursing plan of care and any time the plan of care is amended.<br>• Providers of private duty nursing services are responsible for requesting prior authorization and obtaining renewal of prior authorization.<br>• Requests for prior authorization must be obtained for the regular school year (August/September through May/June). Services provided during the summer months must be prior authorized in addition to the services provided during the regular school year. Remember, schools are responsible for obtaining the physician orders for new or amended requests for prior authorization. Prior authorization requests must be submitted to Mountain Pacific Quality Health Foundation ***in advance*** of providing the service.<br>• Providers are required to send in prior authorization requests two weeks prior to the current prior authorization request end date for recipients receiving ongoing services.<br>• Total number for units of service paid on claims must not exceed those authorized by the Medicaid Utilization Review Department. Payment will not be made for units of service in excess of those approved.<br>• No retrospective prior authorization reviews will be allowed.<br>• To request prior approval submit a completed *Request for Private Duty Nursing Services* form located in *Appendix A: Forms* of this manual and on the Provider Information website under *Forms*. Send completed requests to the contact shown in the second column. |
| • **Outpatient mental health therapy provided outside or concurrently with CSCT** | First Health<br>Phone: (800) 770-3084<br>FAX: (800) 639-8982<br>Address: 4300 Cox Road<br>Glen Allen, VA 23060 | Client Name and ID<br>MHC NPI<br>Procedure code(s)<br>Diagnosis (es) |

## Other Programs

The Children's Mental Health Services Plan (CMHSP) and the Children's Health Insurance Plan (CHIP) do not cover school-based services. For more information on these programs, visit the Provider Information website (see *Key Contacts*).

# Coordination of Benefits

## When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

## Identifying Other Sources of Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information For Providers* manual). If a client has Medicare, the Medicare ID number is provided. If a client has other coverage (excluding Medicare), it will be shown under the "TPL" section. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

## When a Client Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not.

### *Medicare Part B crossover claims*

Medicare Part B covers outpatient hospital care, physician care, and other services including those provided in a school setting. The Department has an agreement with Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]). Under this agreement, the carriers provide the Department with a magnetic tape of claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically and must have their NPI on file with Medicaid.

To avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

In these situations, providers need not submit Medicare Part B crossover claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see *Billing Procedures*).

### *When Medicare pays or denies a service*

- When Medicare automatic crossover claims are paid or denied, they should automatically cross over to Medicaid for processing, so the provider does not need to submit the claim to Medicaid.
- When Medicare crossover claims are billed on paper and are paid or denied, the provider must submit the claim to Medicaid with the Medicare EOMB (and the explanation of denial codes).

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Billing Procedures* chapter in this manual.

### *When Medicaid does not respond to crossover claims*

When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, submit a claim with a copy of the Medicare EOMB to Medicaid for processing.

### *Submitting Medicare claims to Medicaid*

When submitting a paper claim to Medicaid, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must include the provider's NPI and Medicaid client ID number. The Medicare EOMB and explanation of denial codes are required only if the claim was denied.

All Part B Crossover claims submitted to Medicaid before Medicare's 45-day response time will be returned to the provider.

**Remember to submit Medicare crossover claims to Medicaid only:**

- When the referral to Medicaid statement is missing from the provider's EOMB.
- When the provider does not hear from Medicaid within 45 days of receiving the Medicare EOMB.
- When Medicare denies the claim.

- Modifier "22" is billed with the procedure code when a service is greater than the customary service normally entails. For example, this modifier may be used when a service is more extensive than usual or there was an increased risk to the individual. Slight extension of the procedure beyond the usual time does not validate the use of this modifier.
- Modifier "59" is billed for therapies in accordance with the Correct Coding Initiative (CCI) and to be used when codes are considered "mutually exclusive" or "a component of one another."
- Modifiers may also be required when providing two services in the same day that use the same code. See *Multiple Services on Same Date* for more information.

### Multiple services on same date

When a provider bills Medicaid for two services that are provided on the same day that use the same CPT code and are billed under the same NPI and taxonomy, a modifier should be used to prevent the second service from being denied. The modifier "GO" is used for occupational therapy, and "GP" is used for physical therapy. One of the codes needs to have the "59" modifier also for the CCI edit. For example, a school bills with one NPI and taxonomy for all services. The school provided occupational therapy for a client in the morning, and physical therapy for the same client in the afternoon of October 14, 2003. The claim would be billed like this:

| 24. A DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 10 | 14 | 03 | 10 | 14 | 03 | 03 | 0 | 97530 | GO 59 | 1 | $ 22 00 | 1 | | | | |
| 2 10 | 14 | 03 | 10 | 14 | 03 | 03 | 0 | 97530 | GP | 1 | $ 22 00 | 1 | | | | |

### Time and units

- A provider may bill only time spent directly with a client. Time spent traveling to provide a service and paperwork associated with the direct service cannot be included in the time spent providing a service.
- Some CPT codes are designed to bill in units of 15 minutes (or other time increment) and others are "per visit".
- If the service provided is using a "per visit" code, providers should use one unit of service per visit.
- When using codes that are based on a 15-minute time unit, providers should bill one unit of service for each 15-minute period of service provided. Units round up to the next unit after 8 minutes. Please use the following table as an average of the number of units of service to use. If the actual number of minutes providing a service falls between the range of minutes in the first two columns of the chart below, use the number of units in the third column.

- If a CSCT provider sees a client more than one time in a day, the entire time spent with the client that day should be totaled and billed once with the correct number of units as described in the following table.

**Billing for Time in Units**

| Minutes Greater Than | Minutes Less Than | Number of Units |
|---|---|---|
| 8 | 23 | 1 |
| 24 | 38 | 2 |
| 39 | 53 | 3 |
| 54 | 68 | 4 |
| 69 | 83 | 5 |
| 84 | 98 | 6 |
| 99 | 113 | 7 |
| 114 | 128 | 8 |

### *Place of service*

The only place of service code Montana Medicaid will accept is "03" (schools).

## Billing for Specific Services

The following are instructions for billing for school-based services. For details on how to complete a CMS-1500 claim form, see the *Completing a Claim* chapter in this manual.

Medicaid covered services provided under and IEP are exempt from the "free care" rule.

School-based providers can only bill services in the amount, scope, and duration listed in the IEP. Medicaid covered services provided under an Individual Education Plan (IEP) are exempt from the "free care" rule. That is, providers may bill Medicaid for a covered service provided to a client under an IEP even though they may be provided to non-Medicaid clients for free.

### *Assessment to initiate an IEP*

When billing for assessments (evaluations), use the CPT code for the type of service being billed. When the unit measurement is "per visit", only one unit may be billed for the assessment/evaluation. If the evaluation is completed over the course of several days, it is considered one evaluation. Bill the date span with 1 unit of service, not multiple units of service. For example, a speech/hearing evaluation completed over a three-day period would be billed like this:

| 24. A | | | | | | B | C | D | | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DATE(S) OF SERVICE From | | | To | | | Place of Service | Type of Service | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | DIAGNOSIS CODE | $ CHARGES | DAYS OR UNITS | EPSDT Family Plan | EMG | COB | RESERVED FOR LOCAL USE |
| MM | DD YY | | MM | DD | YY | | | CPT/HCPCS | MODIFIER | | | | | | | |
| 09 | 23 | 03 | 09 | 26 | 03 | 03 | 0 | 92506 | | 1 | $ 65 00 | 1 | | | | |

A two-hour psychological assessment (evaluation) would be billed like this (the unit measurement for this code is "per hour"):

| 24. A DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 09 | 23 | 03 | 09 | 23 | 03 | 03 | 0 | 96100 | | 1 | $ 90 00 | 2 | | | | |

## Comprehensive School and Community Treatment (CSCT)

If a provider spent 30 minutes for individual counseling with a Medicaid client, it would be billed like this (the unit measurement for this code is 15 minutes):

| 24. A DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 11 | 05 | 03 | 11 | 05 | 03 | 03 | 0 | H0036 | | 2 | $ 40 00 | 2 | | | | |

The CSCT program must follow the free care rule. That is, if it is free for non-Medicaid children, then it is free for all children.

## Therapy services

Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the school's NPI and taxonomy. Schools are responsible for assuring the proper supervision is provided for aides/assistants (see Covered Services Chapter). Remember to use the CCI edit modifier for all three types of therapy: speech, occupational and physical. See the *Completing a Claim* chapter in this manual. Thirty minutes of individual physical therapy would be billed like this (the unit measurement for this code is "15 minute unit"):

| 24. A DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 | 02 | 03 | 12 | 02 | 03 | 03 | 0 | 97530 | | 1 | $ 40 00 | 2 | | | | |

## Private duty nursing services

Prior authorization is required for these services, so remember to include the prior authorization number on the claim (see the *Completing a Claim* chapter in this manual). Private duty nursing services provided for 15 minutes would be billed like this:

| 24. A DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 09 | 02 | 03 | 09 | 02 | 03 | 03 | 0 | T1000 | | 1 | $ 5 00 | 1 | | | | |

## School psychologists and mental health services

A psychological therapy session of 30 minutes would be billed like this (the unit measurement for this code is "per 30 minute unit"):

| 24. A DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 09 | 02 | 03 | 09 | 02 | 03 | 03 | 0 | 90804 | | 1 | $ 50 00 | 1 | | | | |

## Personal care paraprofessional services

Personal care services provided to a client for 2 hours during a day would be billed like this (the unit measurement for this code is per 15 minute unit):

| 24. A DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 09 | 02 | 03 | 09 | 02 | 03 | 03 | 0 | T1019 | | 1 | $ 24 00 | 8 | | | | |

The CSCT program must follow the *free care rule.*

### *Special needs transportation*

School districts must maintain documentation of each service provided, which may take the form of a trip log. Schools must bill only for services that were provided. Special transportation should be billed on a per one-way trip basis. For example, if a client was transported from his or her residence to school and received Medicaid covered health-related services that day, and then transported back to his or her residence, it would be billed like this:

| 24. A | | | | | | B | C | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | Place of Service | Type of Service | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | DIAGNOSIS CODE | $ CHARGES | DAYS OR UNITS | EPSDT Family Plan | EMG | COB | RESERVED FOR LOCAL USE |
| 09 | 02 | 03 | 09 | 02 | 03 | 03 | 0 | T2003 | | 1 | $ 20 00 | 2 | | | | |

### *Audiology*

An audiology assessment would be billed like this (the unit measurement for this code is "per visit"):

| 24. A | | | | | | B | C | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | Place of Service | Type of Service | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | DIAGNOSIS CODE | $ CHARGES | DAYS OR UNITS | EPSDT Family Plan | EMG | COB | RESERVED FOR LOCAL USE |
| 09 | 02 | 04 | 09 | 02 | 04 | 03 | 0 | 92557 | | 1 | $ 35 00 | 1 | | | | |

## Submitting Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this ***free*** software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's

clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

## Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's NPI followed by the client's ID number and the date of service, each separated by a dash:

| **9999999999** | - | **888888888** | - | **11182003** |
|---|---|---|---|---|
| Provider NPI | | Client ID Number | | Date of Service (mmddyyyy) |

The supporting documentation must be submitted with a paperwork attachment coversheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

## Submitting Paper Claims

For instructions on completing a paper claim, see the *Completing a Claim* chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

## Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibility, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A.* Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

## The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

### Common Billing Errors

| Reasons for Return or Denial | How to Prevent Returned or Denied Claims |
|---|---|
| Provider NPI missing or invalid | The provider NPI is a **10-digit** number assigned to the provider by the National Plan and Provider Enumeration System. Verify the correct provider NPI is on the claim. |
| Authorized signature missing | Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer generated. |
| Signature date missing | Each claim must have a signature date. |
| Incorrect claim form used | The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim). |
| Information on claim form not legible | Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines. |
| Recipient number not on file, or recipient was not eligible on date of service | Before providing services to the client, verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual. Medicaid eligibility may change monthly. |
| Prior authorization number is missing | • Prior authorization (PA) is required for certain services, and the PA number must be on the claim. See the *PASSPORT and Prior Authorization* chapter in this manual. |
| Prior authorization does not match current information | • Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization. |
| Duplicate claim | • Please check all remittance advices (RAs) for previously submitted claims before resubmitting.<br>• When making changes to previously paid claims, submit an adjustment form rather than a new claim (see *Remittance Advices and Adjustments* in this manual). |

## Common Billing Errors (continued)

| Reasons for Return or Denial | How to Prevent Returned or Denied Claims |
|---|---|
| TPL on file and no credit amount on claim | • If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual.<br>• If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim. |
| Claim past 12-month filing limit | • The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter.<br>• To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*. |
| Missing Medicare EOMB | All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper. |
| Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider NPI terminated | • Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment.<br>• New providers cannot bill for services provided before Medicaid enrollment begins.<br>• If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied. |
| Procedure is not allowed for provider type | • Provider is not allowed to perform the service.<br>• Verify the procedure code is correct using current HCPCS and CPT-4 billing manual.<br>• Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type. |

## Other Programs

The Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP) do not cover school-based services. For more information on these programs, visit the Provider Information website (see *Key Contacts*). Additional information regarding CHIP benefits is available by contacting BlueCross BlueShield at 1-800-447-7828 ext. 8647.

MONTANA
Department of Public Health & Human Services

# Completing a Claim Form

The services described in this manual are billed either electronically on a Professional claim or on a CMS-1500 paper claim form. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

When completing a claim, remember the following:

- Required fields are indicated by "*".
- Fields that are required if the information is applicable to the situation or client are indicated by "**".
- Field 24h, *EPSDT/family planning,* is used as an indicator to specify additional details for certain clients or services. The following are accepted codes:

**EPSDT/Family Planning Indicators**

| Code | Client/Service | Purpose |
|---|---|---|
| 1 | EPSDT | This indicator is used when the client is under age 21 |
| 2 | Family planning | This indicator is used when providing family planning services. |
| 3 | EPSDT and family planning | This indicator is used when the client is under age 21 and is receiving family planning services |
| 4 | Pregnancy (any service provided to a pregnant woman) | This indicator is used when providing services to pregnant women |
| 6 | Nursing facility client | This indicator is used when providing services to nursing facility residents |

- Unless otherwise stated, all paper claims must be mailed to the following address:

Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

# Sample Claim

| Field # | Field Title | Instructions |
|---|---|---|
| **Client Information** | | |
| 2* | Client's Name | Enter patient's name as seen on client's Montana's Healthcare Programs information |
| 10d * | Client's ID | Enter the client's ID number as it appears on the client's Montana's Healthcare Programs information. |
| 1a, 9a, 11** | Client's ID | If Client's ID is not located in 10d these three fields are searched for the number |
| 24h* | EPSDT Family Planning | When billing electronically, use "Y." When billing on paper, use "1." |
| **Provider Information** | | |
| 24a shaded area | NDC | Enter the qualifier, N4, followed by the NDC (NDC should not have punctuation, dashes or spaces), units qualifier and units as described by the qualifier |
| 24i shaded** | ID Qualifier | ZZ for the Taxonomy qualifier |
| 24j shaded** | Taxonomy Code | Enter the Taxonomy code for the rendering provider |
| 24j ** | NPI Number, Rendering Prov | Enter NPI Number for the rendering provider. |
| 31* | Signature and Date | Enter Signature and Date |
| 33* | Billing Provider Info | Enter Physical Address with a 9 digit ZIP code and phone number |
| 33a* | NPI # | Enter NPI number for billing/pay-to provider. |
| 33b* | Taxonomy # | Enter the qualifier (ZZ) and the billing provider's taxonomy code |
| **Billing Information** | | |
| 19** | Reserved for Local Use | CSCT Program. If electronic use only 01, 02, 03, etc. If paper, use TEAM 01, TEAM 02, etc. |
| 21.1 - 21.4* | Diagnosis codes | Enter at least one diagnosis |
| 24a* | Date(s) of Service | Enter the dates of service include beginning and ending date even if same |
| 24b* | Place of Service | Enter the code for place of service |
| 24c** | EMG | Emergency Indicator if applicable |
| 24d* | Procedure Code | Enter the procedure code used/ Enter Modifiers if applicable |
| 24e* | Diagnosis Pointer | Enter the corresponding diagnosis pointer (1,2,3,or 4) that refers to the codes in field 21 |
| 24f* | Charges | Enter the total charge for this line |
| 24g* | Days/Units | Enter the days or units used for the procedure |
| 28* | Total Charges | Enter total charges from all line items. |

* = Required Field ** = Required if applicable

# Sample Claim

1500

Replacement Page, April 2008

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Chuckie L.

3. PATIENT'S BIRTH DATE MM DD YY: 04 28 92 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [X] Part-Time Student [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): ( 406 ) 555-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicaid

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, return to and complete item 9 a-d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY: 01 01 07 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 313.31 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

| 24. A. DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 09 | 09 | 03 | 09 | 09 | 03 | 03 | | 92507 | | 1 | $ 30 00 | 1 | | ZZ<br>NPI | 36LP00000X<br>1213456789 |
| 2 | 09 | 16 | 03 | 09 | 16 | 03 | 03 | | 92507 | | 1 | $ 30 00 | 1 | | ZZ<br>NPI | 36LP00000X<br>1213456789 |
| 3 | 09 | 22 | 03 | 09 | 22 | 03 | 03 | | 92508 | | 1 | $ 12 50 | 1 | | ZZ<br>NPI | 36LP00000X<br>1213456789 |
| 4 | | | | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN: 99-9999999 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 123456789

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ $ 72 50

29. AMOUNT PAID: $

30. BALANCE DUE: $ $ 72 50

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Sally Jones 09/30/03

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Public School
123 Education Drive
Anytown, MT 59999

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( 406 ) 555-1234

Public School
P.O. Box 999
Anytown, MT 59999-1234

a. 9876543210 b. ZZ400RT0010X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

## CMS-1500 Agreement

Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

**REFERS TO GOVERNMENT PROGRAMS ONLY**

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

**BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

**SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)**

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION**
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR CHAMPUS CLAIMS:** PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

**MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

## Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double check each claim to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

**Common Claim Errors**

| Claim Error | Prevention |
|---|---|
| Required field is blank | Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied. |
| Client ID number missing or invalid | This is a required field (field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's ID card. |
| Client name missing | This is a required field (field 2); check that it is correct. |
| Provider NPI missing or invalid | The provider NPI is a **10-digit** number assigned to the provider by the National Plan and Provider Enumeration System. Verify the correct provider NPI is on the claim. |
| Prior authorization number missing | When prior authorization (PA) is required for a service, the PA number must be listed on the claim in field 23 (see *PASSPORT and Prior Authorization* in this manual). |
| Not enough information regarding other coverage | Fields 1a and 11d are required fields when a client has other coverage (refer to the examples earlier in this chapter). |
| Authorized signature missing | Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written. |
| Signature date missing | Each claim must have a signature date. |
| Incorrect claim form used | Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim). |
| Information on claim form not legible | Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines. |
| Medicare EOMB not attached | When Medicare is involved in payment on a claim, the Medicare EOMB must be attached to the claim or it will be denied. |

## Other Programs

This chapter also applies to claims forms completed for MHSP services and CHIP eyeglass services.

MONTANA
Department of Public Health & Human Services

# Remittance Advices and Adjustments

## The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

### *Electronic RA*

To receive an electronic RA, the provider must complete the *Electronic Remittance Advice and Payment Cycle Enrollment Form* (see the following table), have internet access, and be registered for the Montana Access to Health Web Portal. You can access your electronic RA through the Web Portal on the internet by going to the Provider Information Web Portal (see *Key Contacts*) and selecting Log In to Montana Access to Health. In order to access the Montana Access to Health Web Portal, you must first complete an *EDI Provider Enrollment Form* and an *EDI Trading Partner Agreement* (see the following table).

After these forms have been processed, you will receive a user ID and password that you can use to log on to the Web Portal. The verification process also requires a provider ID, a submitter ID, and a tax ID number. Each provider must complete an *EDI Trading Partner Agreement*, but if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

RAs are available in PDF format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the Web Portal home page. Due to space limitations, each RA is only available for 90 days.

### *Paper RA*

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

Electronic RAs are available for only 90 days on the web portal.

If a claim was denied, please read the description of the EOB before taking any action on the claim.

The pending claims section of the RA is informational only. Please do not take any action on claims displayed here.

## Sections of the Paper RA

| Section | Description |
|---|---|
| **RA notice** | The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims. |
| **Paid claims** | This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter). |
| **Denied claims** | This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter. |
| **Pending claims** | All claims that have not reached final disposition will appear in this area of the paper RA (pended claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.<br><br>Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number. |
| **CSCT TEAM identification** | The TEAM number is identified under the child's name for paid CSCT Program services. This total payment is forwarded to the contracted mental health agency. |
| **Credit balance claims** | Credit balance claims are shown here until the credit has been satisfied. |
| **Gross adjustments** | Any gross adjustments performed during the previous cycle are shown here. |
| **Reason and remark code description** | This section lists the reason and remark codes that appear throughout the RA with a brief description of each. |

# Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)

PUBLIC SCHOOL
2100 NORTH MAIN STREET
WESTERN CITY MT 59988

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE:10/15/03 PAGE 2 (6)

| RECIP ID (7) | NAME (8) | SERVICE DATES FROM (10) | TO (10) | UNIT OF SVC (11) | PROCEDURE REVENUE NDC (12) | TOTAL CHARGES (13) | ALLOWED (14) | CO-PAY (15) | REASON/ REMARK CODES (16) |
|---|---|---|---|---|---|---|---|---|---|
| **PAID CLAIMS - MISCELLANEOUS CLAIMS** | | | | | | | | | |
| 123456789 | DOE, JOHN EDWARD | 100103 | 100103 | 1 | 97530 | 23.74 | 23.74 | N | |
| (9) ICN 00327411250000700 TEAM NUMBER 06 (18) | | ***LESS MEDICARE PAID********** | | | | | 21.25 | | |
| | | ***CLAIM TOTAL********** | | | | 23.74 | 2.49 (17) | | |
| **DENIED CLAIMS - MISCELLANEOUS CLAIMS** | | | | | | | | | |
| 123456789 | DOE, JOHN EDWARD | 100203 | 100203 | 1 | 92507 | 53.54 | 0.00 | N | |
| ICN 00327511250000800 TEAM NUMBER 06 | | 100203 | 100203 | 1 | 92508 | 21.76 | 0.00 (17) | N | 31MA61 |
| | | ***CLAIM TOTAL********** | | | | 75.30 | | | |
| **PENDING CLAIMS - MISCELLANEOUS CLAIMS** | | | | | | | | | |
| 123456789 | DOE, JOHN EDWARD | 100303 | 100203 | 1 | 90804 | 51.67 | 0.00 (17) | N | 133 |
| ICN 00327611250000900 TEAM NUMBER 06 | | 100203 | 100203 | 1 | 92507 | 53.54 | 0.00 | N | 133 |
| | | ***CLAIM TOTAL********** | | | | 105.21 | | | |

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

## Key Fields on the Remittance Advice

| Field | Description |
|---|---|
| 1. Provider name and address | Provider's business name and address as recorded with the Department |
| 2. NPI number | The 10-digit number assigned to the provider by the National Plan and Provider Enumeration System (NPPES) |
| 3. Remittance advice number | The remittance advice number |
| 4. Warrant number | Not used |
| 5. Date | The date the RA was issued |
| 6. Page Number | The page number of the RA |
| 7. Recipient ID | The client's Medicaid ID number |
| 8. Name | The client's name |
| 9. Internal control number (ICN) | Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information:<br>0 00111 11 123 000123<br>A B C D E<br>A = Claim medium<br>0 = Paper claim<br>2 = Electronic claim<br>3 = Encounter claim<br>4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim)<br>B = Julian date (e.g. April 20, 2000 was the 111th day of 2000)<br>C = Microfilm number<br>00 = Electronic claim<br>11 = Paper claim<br>D = Batch number<br>E = Claim number<br>If the first number is:<br>0 = Regular claim<br>1 = Negative side adjustment claim (Medicaid recovers payment)<br>2 = Positive side adjustment claim (Medicaid reprocesses) |
| 10. Service dates | Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns |
| 11. Unit of service | The units of service rendered under this procedure or NDC code. |
| 12. Procedure/revenue/NDC | The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column. |
| 13. Total charges | The amount a provider billed for this service. |
| 14. Allowed | The Medicaid allowed amount. |
| 15. Copay | A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted. |
| 16. Reason and remark codes | A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA. |
| 17. Deductions, billed amount, and paid amount | Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement. |
| 18. Team number | The number of the CSCT team to which the child belongs. |

### *Credit balances*

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

The credit balance section is informational only. Do not post from credit balance statements.

Credit balances can be resolved in two ways:

1. By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your NPI. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

## Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

### *How long do I have to rebill or adjust a claim?*

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations (see *Credit balances* #2 above) to complete a gross adjustment.

### *Rebilling Medicaid*

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as NPI and taxonomy or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Completing a Claim* chapters.

### *When to rebill Medicaid*

Rebill denied claims only after appropriate corrections have been made.

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Reason and/or Remark code, make the appropriate corrections, and resubmit the claim (not an adjustment).

- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Do not use an adjustment form.
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

### How to rebill

- Check any Reason and/or Remark code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or include insurance denial information, and submit to Medicaid.

Adjustments can only be made to paid claims.

### Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see the *Billing Procedures* chapter, *Claim Inquiries*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12$^{th}$ digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

### When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider NPI, date of service, procedure code, diagnoses, units, etc.).

## How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A.* The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

**MONTANA MEDICAID/MHSP/CHIP**
**INDIVIDUAL ADJUSTMENT REQUEST**

**INSTRUCTIONS:**
**This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).**

**A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION**

1. PROVIDER NAME & ADDRESS: Public School
Name: 2100 North Main Street
Street or P.O. Box: Western City, MT 59988
City State Zip
2. CLIENT NAME: Jane Doe
3. INTERNAL CONTROL NUMBER (ICN): 00327211250000600
4. PROVIDER NUMBER: 1234567
5. CLIENT ID NUMBER: 123456789
6. DATE OF PAYMENT: 10/15/02
7. AMOUNT OF PAYMENT $: 11.49

**B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED**

| | DATE OF SERVICE OR LINE NUMBER | INFORMATION STATEMENT | CORRECTED INFORMATION |
|---|---|---|---|
| 1. Units of Service | Line 2 | 2 | 1 |
| 2 Procedure Code/N.D.C./Revenue Code | | | |
| 3. Dates of Service (D.O.S.) | Line 3 | 10/01/02 | 10/02/02 |
| 4. Billed Amount | | | |
| 5. Personal Resource (Nursing Home) | | | |
| 6. Insurance Credit Amount | | | |
| 7. Net (Billed - TPL or Medicare Paid) | | | |
| 8. Other/REMARKS (BE SPECIFIC) | | | |

SIGNATURE: John R. Smith, M.D. DATE: 10/31/03

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

## Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A.* You may also order forms from Provider Relations or download them from the Provider Information website (see *Key Contacts*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the *Date of Service or Line Number* column.
   - Enter the information from the claim that was incorrect in the *Information on Statement* column.
   - Enter the correct information in the column labeled *Corrected Information*.

## Completing an Individual Adjustment Request Form

| Field | Description |
|---|---|
| **Section A** | |
| 1. Provider name and address | Provider's name and address (and mailing address if different). |
| 2. Recipient name | The client's name is here. |
| 3.* Internal control number (ICN) | There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim. |
| 4.* Provider NPI | The provider's NPI. |
| 5.* Recipient Medicaid number | Client's Medicaid ID number. |
| 6. Date of payment | Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter). |
| 7. Amount of payment | The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.). |
| **Section B** | |
| 1. Units of service | If a payment error was caused by an incorrect number of units, complete this line. |
| 2. Procedure code/ NDC/ Revenue code | If the procedure code, NDC, or revenue code is incorrect, complete this line. |
| 3. Dates of service (D.O.S) | If the date(s) of service is incorrect, complete this line. |
| 4. Billed amount | If the billed amount is incorrect, complete this line. |
| 5. Personal resource (Nursing facility) | If the client's personal resource amount is incorrect, complete this line. |
| 6. Insurance credit amount | If the client's insurance credit amount is incorrect, complete this line. |
| 7. Net (Billed – TPL or Medicare paid) | If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid. |
| 8. Other/Remarks | If none of the above items apply, or if you are unsure what caused the payment error, complete this line. |

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit. If the result is a credit balance, it can be worked off or the provider can pay off the balance by check (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

### *Mass adjustments*

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Electronic RAs are available for only 90 days on the web portal.

## Payment and The RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A). One form must be completed for each provider NPI. See the following table, *Required Forms for EFT and/or Electronic RA.*

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. See *Direct Deposit Arrangements* under *Key Contacts* for questions or changes regarding EFT.

## Required Forms for EFT and/or Electronic RA

**All four forms are required for a provider to receive weekly payment**

| Form | Purpose | Where to Get | Where to Send |
|---|---|---|---|
| Electronic Remittance Advice and Payment Cycle Enrollment Form | Allows providers to receive electronic remittance advices on the Montana Access to Health Web Portal (must also include an EDI Provider Enrollment Form and EDI Trading Partner Agreement) | • Provider Information Web Portal<br>• Provider Relations (see *Key Contacts*) | Provider Relations (see *Key Contacts*) |
| Direct Deposit Sign-up Form Standard Form 1199A | Allows the Department to automatically deposit Medicaid payment into provider's bank account | • Provider Information Web Portal (see *Key Contacts*)<br>• Provider's bank | Provider Relations (see *Key Contacts*) |
| EDI Provider Enrollment Form and EDI Trading Partner Agreement | Allow provider to access their RA on the Montana Access to Health Web Portal (must also include an Electronic Remittance Advice and Payment Cycle Enrollment Form) | • Provider Information Web Portal<br>• ACS EDI Gateway website<br>(see *Key Contacts)* | ACS address on the form |

MONTANA
Department of Public Health & Human Services

# How Payment Is Calculated

## Overview

Though providers do not need the information in this chapter in order to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims. The payment methods described do not apply to services provided under the Children's Health Insurance Program (CHIP).

## Certification of State Match

A state certification of match process allows the state to leverage public education dollars to draw down federal funds. The state of Montana has implemented a state certification of match process for purposes of drawing down Federal Medical Assistance Percentage (FMAP) for the school based fee-for-service program. The FMAP rate fluctuates each year and will be reflected in reimbursements to schools. DPHHS is working in conjunction with the Office of Public Instruction (OPI) in the certification of match process for Medicaid covered school-based health-related services. This process includes all direct services billed to Medicaid under the School-based Health Services program including CSCT services that are written into an IEP.

### *CSCT services included in IEP*

If CSCT services are included on a child's IEP, then the school district/cooperative does not need to do anything else to certify match for federal funds to be drawn down. Health services that are part of the Medicaid School-based Health Services program and are included on the IEP are covered by OPI's certification of match procedure that is based on the trustees' financial summary report utilizing special education expenditures that are documented and maintained at the state level. This greatly simplifies the process for matching federal funds.

### *CSCT services not included in IEP*

The CSCT program, like all other services that are included in the Medicaid School-based Health Services program require certification of the use of local and state funds to match the state portion of the Medicaid funds. Because services are provided to children who do not have an IEP there is a requirement that schools who administer the CSCT program verify that the district has sufficient state and local funds to support the CSCT program in order to draw down the federal funds for children that are receiving CSCT services that are not included on an IEP. This match is required on an annual basis to DPHHS.

This match must come from non-federal sources. State special education funds and federal funds cannot be used for purposes of this match. The following formula will assist district in calculating the district's match obligation:

Medicaid payment for CSCT Services / Current FMAP Rate X Current State Match Rate = Local District Match

The annual certification of match will be due at the end of December of each year. CSCT services are reimbursed to schools by federal Medicaid funds. This means that a school is required to certify non-federal expenditures to cover the district costs associated with CSCT services. Insufficient match will result in a payback.

The annual CSCT Match Statement Reporting Form will be due at the end of January of each year for the previous year's school term. This worksheet is found on the Office of Public Instruction (OPI) MAEFAIRS website. This reporting form uses the reimbursed dollars that were certified previously with the annual certification of match as explained above along with other information the school will provide.

Both the **Certification of Match** and the **Match Satement Reporting Form** need to be returned to DPHHS to keep on file as required by federal match participation rules.

*Appendix C: CSCT* has a *Sample Certification of Match Statement*, which shows a sample of the document that the school district/cooperative will receive annually for DPHHS that shows the amount of money that has been expended on CSCT services and the required state and local funds that must be certified for the federal match. The school district/cooperative must certify, by signing the document, that sufficient state and local expenditures (the amount listed in item 3 of the *Sample Certification of Match Statement*) have been used to support this program. The Certification of Match Statement must be returned to DPHHS. If the school district/cooperative have provided CSCT services to clients as part of the IEP, please contact DPHHS to obtain a breakdown by client to calculate reimbursement for services that were not included on IEPs for matching purposes.

For audit purposes, the district must maintain documentation that validates that local and state dollars were spent. This documentation does not necessarily have to show the exact funds that are certified but must demonstrate that sufficient state and local funds were spent (and that these funds were not used as certification of federal match elsewhere). The documentation that validates non-federal funds used to certify to match must be retained for seven years.

# Appendix A: Forms

- ***Montana Medicaid/MHSP/CHIP Individual Adjustment Request***
- ***Montana Medicaid Claim Inquiry Form***
- ***Audit Preparation Checklist***
- ***Request for Private Duty Nursing Services***
- ***Paperwork Attachment Cover Sheet***

# MONTANA MEDICAID/MHSP/CHIP
# INDIVIDUAL ADJUSTMENT REQUEST

**INSTRUCTIONS:**

**This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information for Providers II* manual, or call (800) 624-3958 in- or out-of-state or (406) 442-1837 in Helena.**

## A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

**1. PROVIDER NAME & ADDRESS**

_____
**Name**

_____
**Street or P.O. Box**

_____
**City** **State** **Zip**

**2. CLIENT NAME**

_____

**3. INTERNAL CONTROL NUMBER (ICN)**

_____

**4. BILLING PROVIDER NUMBER**

_____

**5. CLIENT ID NUMBER**

_____

**6. DATE OF PAYMENT** _____

**7. AMOUNT OF PAYMENT $** _____

## B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

| | DATE OF SERVICE OR LINE NUMBER | INFORMATION STATEMENT | CORRECTED INFORMATION |
|---|---|---|---|
| 1. Units of Service | | | |
| 2 Procedure Code/N.D.C./Revenue Code | | | |
| 3. Dates of Service (D.O.S.) | | | |
| 4. Billed Amount | | | |
| 5. Personal Resource (Nursing Home) | | | |
| 6. Insurance Credit Amount | | | |
| 7. Net (Billed - TPL or Medicare Paid) | | | |
| 8. Other/REMARKS (BE SPECIFIC) | | | |

**SIGNATURE:** _____ **DATE:** _____

**When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).**

**MAIL TO: ACS**
**P.O. Box 8000**
**Helena, MT 59604**

# Montana Healthcare Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____


For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

| | |
|---|---|
| Billing number _____ | ACS Response: _____ |
| Client number _____ | |
| Date of service _____ | |
| Total billed amount _____ | |
| Date submitted for processing _____ | |
| Billing number _____ | ACS Response: _____ |
| Client number _____ | |
| Date of service _____ | |
| Total billed amount _____ | |
| Date submitted for processing _____ | |
| Billing number _____ | ACS Response: _____ |
| Client number _____ | |
| Date of service _____ | |
| Total billed amount _____ | |
| Date submitted for processing _____ | |

**Mail to:** Provider Relations
P.O. Box 8000
Helena, MT 59604

**Fax to:** (406) 442-4402

# Audit Preparation Checklist

For the Montana Medicaid School-Based Services Program, school districts and cooperatives retain responsibility for ensuring that program requirements are met. Schools may not be in compliance if any statement below is checked "No."

| | | | |
|---|---|---|---|
| **Service Provider Qualifications** | | | |
| ___ Yes | ___ No | ___ N/A | Do all individual service providers meet the established provider qualifications for the Montana Medicaid School-Based Services Program for their discipline? |
| ___ Yes | ___ No | ___ N/A | Is there documentation that the service providers are credentialed? |
| ___ Yes | ___ No | ___ N/A | Do you verify and maintain contractor provider credentials? |
| **Services Indicated on IEP** | | | |
| ___ Yes | ___ No | ___ N/A | Is the service that is being billed included in the IEP? |
| ___ Yes | ___ No | ___ N/A | Does the IEP document services that are necessary and being provided as part of the school-based health services program? |
| ___ Yes | ___ No | ___ N/A | Does a team that includes school personnel and qualified providers of health services develop all IEPs? |
| ___ Yes | ___ No | ___ N/A | Does the IEP confirm that services are authorized as medically necessary as certified by a practitioner of the healing arts within their scope of practice? |
| **Service Documentation** | | | |
| ___ Yes | ___ No | ___ N/A | Is the billing documentation accurate for services performed (including student name, date of service, duration of service, type of service and notes that show progress toward student goals)? |
| ___ Yes | ___ No | ___ N/A | Are all service documentation records regularly maintained by the service provider on the day that services are provided? |
| ___ Yes | ___ No | ___ N/A | Are all service documentation records available at a central district location during an audit? |
| ___ Yes | ___ No | ___ N/A | Is evaluation reimbursement only requested for health related evaluations that are completed to determine if a student requires special education services? |
| **Special Needs Transportation Services** | | | |
| ___ Yes | ___ No | ___ N/A | Are special transportation services listed on the IEP? |
| ___ Yes | ___ No | ___ N/A | Did the student receive Medicaid reimbursable services on the same day that transportation reimbursement is being requested? |
| **Billing Information** | | | |
| ___ Yes | ___ No | ___ N/A | Is third party insurance pursued for students with dual insurance coverage? |
| ___ Yes | ___ No | ___ N/A | Do you have documentation retained for a period of six years and three months from the date of service? |
| ___ Yes | ___ No | ___ N/A | Do you have a process in place to maintain contracted providers' service documentation? |

# Private Duty Nursing Services
## School Based Services

MONTANA
Department of Public Health & Human Services

Requests for authorizations should be sent to:

**Mountain Pacific Quality Health, 3404 Cooney Drive, Helena MT 59602**
**phone: (406) 443-4020 or (800) 262-1545 ext. 5850 fax: (406) 443-4585 or (800) 497-8235**

## Request for Authorization

| | | | |
|---|---|---|---|
| Client Name: Last, First, MI | | | Medicaid ID#: |
| Street Address: | City: | State: | Zip: |
| DOB: | Age: | Sex: M F | |
| Will any member of the client's family, or household, who is a licensed RN or LPN, be providing nursing services? ☐ No ☐ Yes | | | |
| School/Provider Name: | | | NPI: |
| School Contact: | Phone #: | | Fax #: |
| School Nurse/Caregiver's name: | | Title/Position: | |
| Physician's name: | | Phone #: | |
| Principal diagnosis: | | | |

## Request for services to be provided in the school

**Number of skilled service hours requested per day:**

Mon- Tues- Wed- Thur- Fri- Total

| | | |
|---|---|---|
| Date school year starts: | Date school year ends: | Summer school dates: |

Skilled services and treatments to be provided (frequency, estimated time/service):

☐ Medication administration: ☐ Oral ☐ G-Tube ☐ IV ☐ IM ☐ SQ

List medications and frequency:

*Name of person who actually administers medications to students:* *Position:*

☐ Trach suctioning/care

☐ Vent care

☐ Sterile dressing changes

☐ Tube Feedings: ☐ Continuous pump ☐ Bolus

☐ Other:

*If meds or treatments are ordered PRN, accurate records of date, time and duration of the treatments must be submitted at the end of the date span.*

☐ Signed Doctor's orders are attached

Signature of person submitting request Date

All private duty nursing services must be prior authorized. Requests for services provided in the school may be authorized for the duration of the regular school year. Services provided during the summer months are additional services that require separate prior authorization. Additional requests may be submitted any time the condition of the child changes, resulting in a change to the amount of skilled nursing services required.

MONTANA
Department of Public Health & Human Services

# Paperwork Attachment Cover Sheet

**Paperwork Attachment Control Number:** _____

**Date of service:** _____

**Billing Provider number:** _____

**Client ID number:** _____

**Type of attachment:** _____

## Instructions:

This form is used as a cover sheet for attachments to electronic and paper Montana Healthcare Programs (Medicaid/MSHP/CHIP/IHS) claims sent to ACS. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's billing number, the client's ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from the Montana's Healthcare provider website at **www.mtmedicaid.org**. If you have questions about which paper attachments are necessary for a claim to process, please call ACS Provider Relations at (406) 442-1837 or (800) 624-3958**.**

Completed forms can be sent to: ACS
P.O. Box 8000
Helena, MT 59604 OR
FAX to: 1-406-442-4402

### Credit Balance Claims
Adjusted claims that reduce original payments, causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the remittance advice until the credit has been satisfied.

### Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

### DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

### Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

### Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

### Electronic Funds Transfer (EFT)
Payment of medical claims that are deposited directly to the provider's bank account.

### Emergency Services
Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

### Experimental
A non-covered item or service that researchers are studying to investigate how it affects health.

### Explanation of Medicare Benefits (EOMB)
A notice sent to providers informing them of the services which have been paid by Medicare.

### Fiscal Agent
ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

### Free Care Rule
If a service is free to non-Medicaid clients, then it must also be free to Medicaid clients. Medicaid cannot be billed for services that are provided free to non-Medicaid clients.

### Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

### Gross Adjustment
A lump sum debit or credit that is not claim specific made to a provider.

### HCPCS
Acronym for the Healthcare Common Procedure Coding System, and is pronounced "hick-picks." There are three types of HCPCS codes:

- Level 1 includes the CPT-4 codes.
- Level 2 includes the alphanumeric codes A - V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by CPT-4 coding.

### Health Insurance Portability and Accountability Act (HIPAA)
A federal plan designed to improve efficiency of the health care system by establishing standards for transmission, storage, and handling of data.

### ICD-9-CM
*The International Classification of Diseases, 9th Revision, Clinical Modification.* This is a three volume set of books which contains the diagnosis codes used in coding claims, as well as the procedure codes used in billing for services performed in a hospital setting.

### Indian Health Service (IHS)
IHS provides health services to American Indians and Alaska Natives.

### Individual Adjustment
A request for a correction to a specific paid claim.

### Internal Control Number (ICN)
The unique number assigned to each claim transaction that is used for tracking.

### Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

### Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

### Montana Access to Health (MATH) Web Portal
A secure website on which providers may view clients' medical history, verify client eligibility, submit claims to Medicaid, check the status of a claim, verify the status of a warrant, and download remittance advice reports.

### Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

### Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

### Usual and Customary

The fee that the provider most frequently charges the general public for a service or item.

### WINASAP 2003

WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information, contact the EDI Technical Help Desk (see *Key Contacts*).

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